Proposition 36
"Making It Work" 2003
Building on Success

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With **Beth Ruyak** of Sacramento acting as emcee, the conference opened with words of welcome from **Kathryn P. Jett**, director of the State Department of Alcohol and Drug Programs, and **David Deitch**, director of the Addiction Training Center at the University of California at San Diego (UCSD).

Jett thanked The California Endowment and UCSD for their part in organizing the conference. She noted that registration for the conference exceeded 400 and said she was pleased at the large number of participants attending the annual conference for the third time. Attending were 30 Judges, 16 high-level court staff, 76 probation officers and administrators, 9 parole agents and supervisors, 31 public defenders, 29 district attorneys, 35 treatment providers, and 112 representatives of county health and human services agencies.

Many states are interested in what California is doing to implement Proposition 36 [the Substance Abuse and Crime Prevention Act of 2000 (SACPA)] as they examine policies, Jett declared. She said, people from California agencies may be asked to participate in a national forum later this year to help states understand what to expect if they adopt principles similar to those in Proposition 36. She said outsiders are impressed by the progress made in California in involving Judges, attorneys and others in a comprehensive system to provide an alternative of treatment for non-violent drug offenders. The series of "Making It Work" conferences has opened the way for counties to share their experiences and solve mutual problems in establishing procedures for handling Proposition 36 cases. Other milestones have included the passage of legislation providing funds for drug testing, which had not been included under Proposition 36, and the awarding of a contract to the University of California at Los Angeles (UCLA) for a five-year evaluation of the implementation effort.

"These conferences have embodied a commitment to collaboration, a commitment to honesty, a commitment to putting out on the table what is working and what isn't working, so that we at the state level can do our job in serving you," Jett said. "Each conference builds upon the previous conference , and we expect that later this year things will look a little different." One possibility, she added, is that a Proposition 36 training session will be held specifically for Judges, convened by and for Judges.

Jett also noted that President Bush had talked about substance abuse treatment and recovery in his 2003 State of the Union message. A $600 million increase in federal funds for drug treatment is proposed over the next three years, including a plan providing for "vouchers" for individuals to use in obtaining treatment at the community level.

She turned to budget shortfalls which are plaguing many states and described how a process of "realignment" has been proposed by Governor Davis to help deal with a $36 billion

state budget deficit in California. Realignment would take funding for various essential programs, including Proposition 36, out of the State General Fund and support them with new sources of funding. Where Proposition 36 is concerned, this proposal would shift the responsibilities for evaluation, audit and oversight to the counties, she said. Various budget and tax issues will be threshed out during the coming months. Until a budget is passed, she said, it is business as usual as far as her department and staff are concerned. "The law is the law and we are implementing Proposition 36 as the law is written, and we will continue to do so until we're instructed differently by the Legislature." Jett went on to report that ADP is partnering with the Department of Mental Health in sponsoring a workgroup on co-occurring disorders, a topic which has been cited as one of the top concerns of county teams. The group will look for the best ways to coordinate treatment services at the local level for Proposition 36 clients with co-occurring disorders. "What we're finding out is that there are a lot of programs out there that are capable of dealing with these clients, but we haven't identified them as such." Technical assistance in this area will be offered.

On another subject, she said that ADP was nearly ready to conclude work on the regulatory process for counselor certification. Under the proposed rules, current individuals who are practitioners and are not certified will have five years to gain certification.

Del Sayles-Owen, deputy director at the ADP and head of the Office of Criminal Justice Collaboration, reviewed progress in the implementation effort. She pointed out that a brochure explaining Proposition 36 has been published. She also echoed Jett's assertion that ADP will follow all mandates in the law until or unless there is a legislated change. "It is critical that we adhere to the implementation time-frame that we've laid out for ourselves, " she said. "In the event there is not a change in the law we want to make sure that everything we do is very timely." The Department will adhere to regulations requiring the submission of County Plans by May 1 of each year, with guidelines to be issued by ADP in early March 2003. "We've implemented some system changes to enhance the ease of input for county plans, and training is being provided at this conference," she added. Preliminary allocations for Fiscal Year 2003-04 will also be released in March for use in planning. Also, the ADP Fiscal Workgroup is reviewing the SACPA allocation formula, based on a review of expenditures during the first year and alternative methods of fund allocation. She added that all 58 county plans for Fiscal 2002-03 have been approved; and, Dr. William Ford of Health Systems Research is conducting a workshop on the 58 County Plan Summary at this conference.

Turning to policy development, Sayles-Owen said ADP recently issued two major All County Lead Agency (ACLA) letters on policy issues. Letter ACLA 02-18 clarifies how to calculate the "12 months" of treatment allowed in the law. It states that a client may experience numerous interruptions in treatment, and to maximize success, the 12 months may be calculated based on the cumulative total number of days that he or she has been treated. Another letter, ACLA 02-19, responds to counties that want to provide up to six months of SACPA funding to continue Narcotic Replacement Therapy (NRT) as a component of aftercare. The policy allows continued provision of NRT for clients who meet certain criteria. The client must meet the treatment goals in the plan, and the plan must have been developed with the treatment provider and approved by the court. Still being examined are policy questions on additional issues, including how successful completion of treatment is defined for individuals on NRT, the allowability of court costs covered by the term "made necessary by the Act," and ways to deal with the problem of out-of-county supervision.

ADP is still working on improving coordination of services between various agencies and organizations, especially health maintenance organizations, the Department of Rehabilitation, and the Department of Corrections. For parolees, the system has been redesigned so referrals will come from the assigned regional parole agent instead of from the Board of Prison Terms. At a workshop at this conference, staff will examine this new procedure. Also, a special subcommittee of the ADP Statewide Advisory Group (SAG) is working to improve the interface with Substance Abuse Services Coordinating Agencies (SASCA), and to develop a mental health screening tool for use with parolees.

Sayles-Owen said she was pleased to report that all counties had submitted expenditure reports and client counts for Fiscal Year 2001-02, and this information is being validated for inclusion in the Second Annual Report to the Legislature. An evaluation of the SACPA Reporting Information System (SRIS) is being carried out under a contract with California State University at Bakersfield (CSUB). The evaluators are seeking information from 15 focus counties to develop improvements. In the area of county reporting and audits, she said, ADP is working with several counties on the submission of annual financial status reports that were due on September 30, 2002. "Our goal is to avoid levying any penalties on any counties for late or missed reports," she said. "We've been successful so far." The department has issued 50 final audit reports for Fiscal Year 2000-01,with some questions involving administrative overhead, provider services that do not reconcile to SACPA clients served, and inappropriate handling of remodeling costs.

She went on to a review of the SACPA First Annual Report to the Legislature, completed in November 2002 and now posted on the Internet. "The early data is relatively positive," she said, "but the information covers only the first six months, the start-up period, and should not be considered conclusive." The information was obtained from several systems, including SRIS and CADDS (the California Alcohol and Drug Data System). Much of it came from California's 12 largest counties. "The report does not include criminal justice data on SACPA clients, largely because of the reporting sources that we used. The long-term evaluation study will address data linked to criminal justice outcomes." The preliminary findings also do not include data on delivery of additional services supplemental to treatment, and the department is working with CSUB to improve the collection and reporting of data. Sayles-Owen summarized the First Annual Report by answering a series of questions on the first six months of SACPA data:

How many SACPA offenders were referred from criminal justice to treatment admission? Based on data from the 12 largest counties, there were an estimated 12,000 treatment placements, representing about 60 percent of those referred. Regarding the gap between the number referred and the number of placements, she said anecdotal reports suggest some clients may have been between referral and treatment when the counts were taken. "Counties also are struggling with the issue of no-shows," or clients who are referred but do not show up for treatment. She said there is a continuous need to motivate and engage clients. Sessions at this conference are designed to help counties deal with this issue.

How did the service delivery system respond to the anticipated increase in the demand for services? Overall, there was a 42 percent increase in licensed and certified programs. This included an increase of about 17 percent in licensed residential facilities, and an increase of 81 percent in outpatient programs. The ADP Licensing and Certification staff were able to process all applications in a timely manner.

What do SACPA clients admitted to treatment look like? Seven percent of individuals entering the program in the first six months were parolees. As for age, the data show that clients

are older than some counties expected. More than 53 percent were between the ages of 31 and 45 when admitted to treatment. Almost 63 percent said they were younger than age 20 when they first started using their primary drug, and more than 21 percent reported being under 15 years of age at first use. Methamphetamine was the drug of choice for nearly half of the clients (48 percent), with cocaine and crack a distant second at just over 15 percent.

What treatment services were received by SACPA clients? Some 76 percent received outpatient treatment, and 12 percent went into long-term residential treatment. "That does not necessarily reflect what was needed in all instances," Sayles-Owen pointed out. "Some counties report that their clients are requiring a significantly higher level of care than expected. As a result, some counties are facing shortages of residential treatment services. Sometimes they are using combinations of outpatient day treatment and sober living housing to meet that need."

How much was spent for SACPA purposes? In the first six months, the 12 largest counties spent 15 percent of the total funds ($124.6 million) available to them. Of the $124.6 million, $38.9 million was rolled forward from Fiscal Year 2000-01. The expenditure rate for the first six months reflects the fact that many counties experienced a slow start-up of client flow. "We do expect that to escalate throughout the first year," she said.

How were the dollars distributed? Although counties had estimated that 79 percent of their funds would go for treatment and 21 percent for criminal justice, the experience in the first six months was that 64 percent went for treatment and 38 percent for criminal justice. "It is too early to know what the actual split will be," she said. "In some counties they're anticipating a shift over time toward treatment. In the first six months, a lot of costs went to the administrative set-up and those costs will not continue as more people move into treatment."

How do SACPA clients compare to other clients admitted to treatment? Of all persons tracked as admitted to treatment through CADDS, SACPA represents 9.4 percent. With regard to gender and ethnicity, the SACPA clients look very similar to other treatment populations. While SACPA clients used methamphetamine as their primary drug in 48 percent of the cases, but the primary drug of choice in the general treatment population was heroin, at about 36 percent. "We know that some of this difference can be explained by the difference in reporting requirements for methadone providers."

Sayles-Owen said the department hopes to have all data for the first year of Proposition 36 implementation collected and analyzed for inclusion in the Second Annual Report to the Legislature to be delivered in the spring of 2003. This data will be augmented with data collected by UCLA in its evaluation and will address questions covered in the First Annual Report. It will also discuss the implementation challenges that the counties face. The UCLA evaluation involving the ten focus counties is on schedule, she said.

She pointed out that, regardless of budget uncertainties at this time, the next County Lead Agency Implementation Meeting (CLAIM) will continue with funding by The California Endowment, and is currently scheduled for October 2003. She added that the UCLA Addiction Technology Transfer Center (ATTC) has received about $100,000 in federal funds to provide technical assistance for implementation of Proposition 36. UCLA and UCSD will be coordinating their efforts in this area. She said ADP is committed to ensuring that there is collaboration among all stakeholders and organizations during this year's planning process. During this period, the Statewide Advisory Group and the State Agency Meetings will continue to provide guidance and coordination.

In a brief question period, Sayles-Owen said she expected the Second Annual Report would show that the number of treatment placements had more than doubled. She added that the

percentage of offenders going into treatment—60 percent in the first report—is expected to be as high as 70 percent in the new report.

The Courts: Critical Concerns and Responses

Judge Stephen Manley, Superior Court, Santa Clara County, Moderator

Judge Stephen Manley conducted a panel discussion with four other Judges from counties of various sizes serving as panelists. The panelists were: **Judge Doris Shockley** of Yolo County, **Judge Rogelio Flores** of Santa Barbara County, **Judge Gary Ransom** of Sacramento County, and **Judge Patrick Morris** of San Bernardino County. Judge Manley said the panel would discuss several judicial issues and questions that had been raised as counties moved into implementing Proposition 36. He said each of the five Judges is committed to the idea of drug treatment. They have been handling Proposition 36 cases since the start of implementation, and the five of them supervise and monitor more than 3,000 clients. "One thing that everyone needs to recognize about Proposition 36 is that the Judge is the gatekeeper," Manley said. "The Judge is the first person the client has a relationship with because, according to law, we cannot order treatment and start spending Proposition 36 money until the offender has plead guilty and been sentenced. The Judge wants to really motivate the client. So, to make Proposition 36 work, it boils down to trust. Will the client trust the Judge?"

Many counties and courts have raised the issue of the lack of a uniform system for dealing with cross-jurisdictional issues arising in connection with Proposition 36. Treatment normally is provided in the client's county of residence, but supervision and court oversight will occur in the county where the crime was committed. Clients may be forced to travel long distances from the county of residence. How can a Judge modify a treatment plan in cases like this? The California Judicial Council has drafted a proposed change in statute and asked the Legislature to amend the Penal Code to authorize the sentencing Judge to transfer jurisdiction to the Superior Court of the county of residence for supervision and treatment, and hopefully the issue will be resolved in this Legislative session. Judge Manley then set out a general overview of the procedures followed by each member of the panel of Judges to expedite their Proposition 36 cases to move clients into treatment promptly and keep them in treatment. Each Judge approaches cases and problems in a different way, reflecting the local collaboration in their respective courts.

Turning to specific questions raised among the counties, Judge Manley posed the question of what happens when a treatment provider concludes that a client is unamenable to treatment of any kind. Judge Morris said he had never received such word from a treatment provider in the 18 months since Proposition 36 took effect. Judge Ransom, however, said he has encountered this problem, and generally calls members of the treatment team into his court to find out why the client is not amenable. "Most of the time I go along with the finding but sometimes I determine that the person deserves another shot," he said. Judge Flores reported that about 10 of the 560 persons coming into his county's program in 18 months had been reported unamenable to treatment. He said generally the county's treatment providers are invited to review the individual's case and decide if one of them is willing to make another attempt at treatment. "We tend to refer persons from one program to another…before we find them

unamenable." Judge Shockley recalled two cases in which defendants were sent to prison after the public defender and district attorney agreed that they were unamenable to treatment.

The next issue discussed related to the dually diagnosed and mentally ill who may potentially be found unamenable for substance abuse treatment. Judge Flores noted that one of the benefits of having a multi-disciplinary team working on Proposition 36 cases is the ability to move a client from one treatment modality to another, and persons who are seriously mentally ill can be moved into mental health court. Judges Flores and Morris both noted that their mental health courts are not part of the Proposition 36 system, although Judge Morris pointed out that in San Bernardino County there is a Proposition 36 program for clients with co-occurring disorders. Judge Morris added that it may be necessary to "lower the bar substantially" to move such clients through the system because of the special problems they present.

Judge Manley next discussed probation violations and the distinction between drug-related violations and non-drug-related violations. He emphasized that initial determinations made now relating to the nature of the violation are subject to change based on new interpretations of the statutory language by the Courts of Appeal in the future. "Trial Judges make the first call when there is a new law, but at some point in time the Court of Appeal will tell us we were wrong or we were right." He asked members of the panel to discuss the process they follow with probation violations. Judge Flores said the Probation Department files a formal notice of probation violation and violators are arraigned in his court, and in such cases he generally discusses the case with the treatment provider. The public defender represents all Proposition 36 defendants. Judge Morris said in his court the probation officer files a report after a violation If it is a first violation, the treatment team may recommend an enhancement in the defendant's treatment program, and the court generally goes along with it. Judge Manley then asked if any of the Judges had ever had a *contested* violation of probation. Although Judges Morris and Flores said they never had, Judges Ransom and Shockley said they often arise and may require full-blown hearings.

Then the panel addressed the question of Judges holding "ongoing reviews" of clients' progress, including violations of probation and their consequences. Why have reviews? Judge Morris considered reviews a matter of trust. "If the clients believe the court system has a bottom-line concern about their health and future, they and their attorneys will work with you. They will admit probation violations if they believe the next chapter is going to be enhanced treatment." They may even acknowledge a third violation if they know there is a drug court program. "They see the celebration of successful graduates, they see the employment opportunities, they see the GED's obtained by others in the courtroom in the same programs where they just screwed up. They see that the Judge really cares about people and seems to understand 'what I need and what my family needs.'"

Judge Manley turned to the issue of violations that are not drug-related, such as a new conviction for driving with a suspended license. Judge Flores said it was his intention to give the person more tools to correct his behavior. Judges Morris and Flores agreed that one course is to provide that a new non-drug offense may lead to a modification to require a custody treatment program, followed by a return to community treatment upon release. Judge Ransom pointed out that getting off drugs is not easy, and his court uses a "carrot and stick" approach to give offenders a lot of chances. Sanctions or interventions might include sitting in the courtroom for eight hours, or doing community service. Judge Flores said the aim in non-drug or multiple non-drug and drug violation cases where a defendant may be disqualified is to modify the person's behavior. The offender might go into custody for a couple of days. "We talk to them. They need

to take ownership of their recovery." They may be required to attend 12-step meetings on a daily basis. They may be ordered to move if they're living with an addict.

There was a discussion of whether or not rules of confidentiality in treatment can hinder a court's effort to find out what circumstances may lie behind a violation? The Judges commented that what is important to them is the progress or lack of progress of the defendant in treatment; not the specific details of issues that are being discussed in treatment. Therefore, confidentiality is respected and does not interfere with the interaction between the Judge, the team, and the defendant.

The subject then turned to how long probation should continue after the completion of treatment. Judge Manley pointed out that the maximum probation for a felony is five years and for a misdemeanor three years. Judge Flores said his court provides for three years; Judge Ransom three to five years; and, Judge Morris three years for felonies, two for misdemeanors. Some of the Judges reduce the length of probation once the defendant successfully completes treatment and has refrained from the use of drugs.

The Judges were then asked to describe how they marked or determined the completion of treatment. Judge Ransom said he believes it should take six to nine months, with additional time for aftercare. When he determines that a defendant has, in fact, completed treatment successfully, the Judge holds a graduation; and, if the defendant has completed probation as well, he tears up the original complaint as a part of the ceremony.

Judge Manley then raised the question: What happens when a client who has been found to have successfully completed treatment, but is still on probation, is charged with a new drug offense? Judge Morris said he would start treatment again for some clients and extend the probation for other clients. The client may go through treatment more quickly the second time if it's a simple one-event relapse. Judge Flores said that in his county the offender would start a new year of treatment with six months of aftercare. Many clients ask how long they are going to be in treatment. "I remind them that treatment is a lifelong process, and we urge them to stay involved with the 12-step community after they graduate."

Judge Manley then asked the Judges how they treat the issue of continued methadone use by clients who otherwise have completed treatment. Judge Morris said clients who are opiate users have the right to choose narcotic replacement therapy as their mode of treatment and many have done so. His county is making an effort to assure that these clients receive long-term counseling in addition to daily doses of methadone. Judge Flores said his county is still developing a methadone treatment program. Judge Shockley said her county uses services in another county for such treatment.

Finally, Judge Manley asked the Judges: What happens to Proposition 36 clients who have had three probation violations and are no longer eligible for treatment and probation under the proposition? Judge Morris said treatment would continue regardless, as long as the person has not committed a new serious offense. He pointed out the importance of drug court for these offenders. Judge Ransom said some who were under a suspended sentence would be "on their way to prison." Judge Flores said his county would try to keep the client in treatment as long as possible. Judge Shockley said she would keep the person on probation and in treatment not funded by Proposition 36 if possible.

Relapse Prevention and Continuing Care

Moderator: Sushma Taylor, Ph.D., Executive Director, Center Point, Inc.

Sushma Taylor introduced a panel for discussion of issues surrounding relapse prevention and continuing care. The panelists were: **Toni Moore,** Administrator of the Alcohol and Drug Services Division of the Sacramento County Department of Health and Human Services; **Steve Loveseth**, Manager of the Alcohol and Drug Services Division of the Contra Costa County Health Services Department; **Susan Bower**, Proposition 36 Coordinator for Alcohol and Drug Services of San Diego County; **Janice Stafford**, acting Program Chief and Interim Program Director for Plumas County; and, **Lisa Cox**, a licensed marriage and family therapist who is the Behavioral Health Clinic Program Manager for court services in Butte County.

"Aftercare should not be an afterthought," Taylor declared. "Treatment and continuing care are basically essential components in the process of rehabilitation and, eventually, community reintegration. Rehabilitation begins in treatment programs with the development of a commitment to change and opportunities for clients to acquire the skills necessary to bring about this change." Continuing care is the "first line of defense" against a return to drug use. Continuing care can be conceptualized as therapeutic activities that function to maintain the gains achieved in early phases of treatment rather than activities aimed at developing new skills. She added that aftercare allows for early detection of relapse.

After discharge from treatment, aftercare may provide an opportunity for clients to evaluate new behaviors, Taylor continued. "This is important because, as we know, recovery requires that clients make major lifestyle changes." She went on to discuss various "change processes" and noted that research supports the idea that aftercare services should focus on recovery maintenance and support for those who have relapsed. "It is important to distinguish between primary treatment services, which are designed to break dependence on drug use, and continuing care services, which should be designed to sustain abstinence by assisting in engaging in pro-social activities," she said. Community integration must follow treatment, with clients developing social networks in the community. Such activities can be supportive, educational, recreational, and therapeutic; but, all should be designed to reinforce the goals of treatment. Continuing care should promote distance from the drug culture and provide support and practice in activities that are conventional in community life. It should promote a sense of belonging and personal competence. The services should provide some sort of meaningful attachment to the community, whether through family unification or a satisfactory vocational development.

Dr. Taylor emphasized that relapse prevention strategies are only one aspect of continuing care. Other aspects of community integration include developing personal and social responsibility and civic involvement; creating a home environment, participating in a parental support group, daycare for children, ongoing peer support, leisure activities, and participation in self-help groups. Regarding the need for enjoyable leisure activities, she pointed out that former drug and alcohol users often have difficulty "having fun." She then enumerated the variety of services that can be provided as part of continuing care: case management, budget management, credit repair, parent training, career advancement, job retention support, income enhancement, child care, random drug testing, recreational activities, life skills training, and family unification.

At Center Point, Dr. Taylor said, there is skills training that includes conflict management and social adaptation skills. "We want clients to develop better problem-solving skills and to be

able to make the right decisions." Support groups in aftercare talk about cross-addiction patterns, spirituality, and leisure time issues. "We also want them to talk about the anxiety and conflict they have in their new roles—that is, the role of being in recovery." Among vocational issues, she said, clients may need help in adjusting to the environment of work, and issues such as time, money, boredom, and fatigue. "As counselors we need to cue in on how well clients feel that they are doing in their recovery." Other vocational issues include logistical problems such as child care, transportation and clothing, and developing "work-related values." Job retention strategies also are important. "We know from experience and the literature that it is not difficult for our clients to get a job—it is difficult for them to hold on to a job." Career advancement is an important issue for clients who had easy money when they were using and dealing in drugs and now have not-so-easy money.

Center Point provides transitional housing as a means of maintaining the gains that have been made in residential treatment, Taylor continued. Length of stay in a treatment facility can be shortened by transitioning clients into subsidized low-cost housing. Finally, it is important to do follow-up and tracking as part of long-term aftercare and to assure that clients are engaged in alumni activities and volunteer work.

Toni Moore discussed the program for relapse prevention in Sacramento County. She said it is important to differentiate between a "temporary lapse or a slip," which is a one-time use and generally not catastrophic or regressive in nature, and a "full relapse," which is a return to uncontrolled substance use following a period of sobriety. The latter is a serious situation accompanied by powerful negative emotions, such as intense anxiety, confusion, guilt, embarrassment, and shame. "When we see someone in a full relapse, we usually see that they're disengaging from treatment; not maintaining contact with their probation officer or parole agent; missing work and family obligations; and, generally blowing off their responsibilities," she said. Things that can lead to relapse are unresolved stress, perhaps from failure in a relationship; negative emotions, or the flip side, extremely positive emotions that are used as a point of celebration and a reason to go out and use again. Relapse may result from social pressure or use of another substance that triggers an association with the original drug use.

Relapse prevention can be defined as a set of strategies aimed at meeting the challenges and helping maintain a clean and sober lifestyle, she continued. Some approaches include looking at social supports, lifestyle issues and severe lifestyle changes, cognitive behavioral options, and the thought processes that surround behavioral decisions in response to emotional situations. When faced with a client who has relapsed, it is important to look at the extent of the situation. "If it is just a slip, then you can approach it as a learning experience within the context of treatment." You can analyze the triggers that led to the drug use. "If you do this, it can help reduce the shame and the guilt and the doubt that the individual is feeling at that time. Ultimately, what we want to do is help people maintain their sense of integrity, and in essence re-engage in treatment and pick up where they left off."

In the case of a full relapse, she continued, we believe there should be a full assessment, taking a look at the individual's drug use and the circumstances surrounding it, helping identify the triggers that led to the relapse, and addressing those areas of bio-psycho-social functioning that are part of an assessment. The relapse might be relationship-related, or related to physical or mental health. The next step is to develop strategies or interventions that can help the person re-establish sobriety. Moore said she believes that only in a minority of cases would a relapse require an adjustment in the level of care. "Sometimes what they may need is an increase in the treatment activities within the existing level of care," she said. "If clients are in an intensive

outpatient mode when they relapse, try to avoid automatically thinking that they need to go into detox or residential care. They may just need an enhancement of what it is you're giving them—more individual sessions, more case management activities, more group sessions."

The Sacramento County program includes a specific relapse group, Moore explained, and it is used as a sanction by the court. They are stand-alone groups, and are open-ended so people can float in and out of them for a varying number of sessions Usually people are directed to attend a minimum of three sessions, sometimes more. In the session they focus on the emotional, cognitive and behavioral processes that led to the relapse, and develop a relapse-prevention plan for each individual. Sacramento County also holds regular multi-disciplinary team meetings which have been extremely helpful, Moore said. "When someone is beginning to have difficulty in treatment we can proactively look at what kind of interventions can be employed at that point." The county's program also emphasizes the importance of 12-step meetings, especially if there has been a relapse. The aim is to create aftercare plans that are tailored to the individual.

Proposition 36 graduates in Sacramento formed their own alumni group and called it "36 to Life." According to Moore, "This really reinforces the idea that recovery is a lifelong process. You don't just get this little blip [or episode] of treatment and you're done."

Steve Loveseth, of Contra Costa County, opened his presentation by noting that when a person in alcohol or drug treatment has a relapse, the tendency by some is to kick them out of treatment. "If I had a heart attack and was in intensive care, and then had another attack, I don't think the doctors would tell me to leave because I wasn't cooperating in my recovery." While there is a lot of talk about a "disease model" of addiction, the model is not always followed in responding to relapse.

In Contra Costa County, he said, relapse prevention is involved throughout the treatment process. "In our model we keep people on formal probation throughout most of their treatment phase. As they go into continuing care for relapse prevention they go on court probation and need to come back before the Judge for periodic reviews, and get drug testing and other services." Staff members meet clients in court as soon as their cases are adjudicated, doing a "mini-screening" to try to ferret out mental health problems, homelessness, or other issues that might be linked with relapse. Research on relapse prevention generally talks about stress and stressors, and the county's model is designed to reduce stress. "We have people who guide clients through our system right from the beginning—invite them into our family, in a way." Alumni also enter the picture to help reassure the client. Clients also can get immediate advice and support through an "800" phone number.

Loveseth emphasized that assessment is a process that continues throughout treatment. Those who have problems during treatment are referred to a Recovery Gateway Unit, or RGU. This is a regional center where multidisciplinary teams review a client's case and get the client into a relapse prevention group, a mental health group or another type of group. As for continuing care, he noted that as clients "move down the road" they need more sophisticated services, such as couples counseling, partner reunification, and parenting. He added that drug testing funding earmarked by the state was paying for random drug testing of the Proposition 36 clients. "Drugtesting can be a great relapse prevention tool," he said.

Susan Bower said San Diego County had decided early on to abandon the term "Proposition 36" to describe its program and instead was calling it "Route 36: Roadway to Recovery." People in 12 months of treatment will often encounter "bumps" in the road. The responsibility of everyone on the treatment team is to identify those bumps and help smooth them out.

Bower said her county, like many others, had found that Proposition 36 clients often are not new to treatment. "The role of treatment is to link them to community resources," she said. "We may be planting seeds for people who are new, or we may be just watering some seeds that have been dormant a while." Treatment under Proposition 36 and the period of aftercare is just a point along the way of recovery. She compared treatment to a hub with tentacles reaching out into the community where services are available. "Our role in relapse prevention is to keep the treatment program as their point of reference, whether it is the last treatment program they were discharged from, or whether it is the first treatment program they went through."

She gave some examples of flexibility in San Diego County treatment programs—having computer labs as part of the program, having a GED teacher as part of the program, having licensed child care off-site, and having a coffee shop where people in treatment work alongside people who are not in treatment.

Janice Stafford pointed out that Plumas County has a population of only 20,000 and its Proposition 36 program is still a "work in progress." She pointed out that in a small county it is important to integrate various treatment services so that each one is not "personality driven" by one counselor or director. She said it has been unnecessary to "reinvent the wheel" because there are national standards of treatment, and individualized treatment is recognized as the most effective approach. "We have a variety of groups to meet individual needs." A co-occurring disorders group, for example, helps clients cope with mental health symptoms in an atmosphere where they feel comfortable talking about their problems. Another group concentrates on parenting in recovery. There are also gender-specific services and groups for men and women.

"We have levels of care, so if someone is having a hard time staying clean and sober, we don't go immediately from one or two sessions a week to residential treatment but can gradually increase their level of care in an outpatient setting," Stafford said. The program also provides for reducing the level of care so clients can be "weaned" from treatment without abruptly ending when they must be on their own. The treatment program tries to help drug users make a connection between their drug use and what is happening elsewhere in their lives. It includes education about the bio-chemical process affecting what they are going to experience early in their recovery, such as mood swings and uncomfortable emotions.

Lisa Cox began by stating, Butte County is a predominantly rural county with a large geographic area and a population of about 200,000. As a result, its additional services for people in treatment are spread thin. The County's Behavioral Health Department provides assessments and referral to contracted levels of care, and its treatment team provides all the outpatient treatment. All of the residential treatment providers with Proposition 36 contracts have aftercare groups that serve as a "family" for people in treatment, but clients also are referred back to the county's Proposition 36 team for reassessment, and are assigned to outpatient groups.

The county provides four "phases" of groups which correspond to levels of treatment. The fourth phase is an aftercare group where clients remain until dismissal. Once the client has completed all requirements—including getting a driver's license, earning a GED, becoming employed, or enrolling in a training program—there is a follow-up assessment and preparation of a written, three-month aftercare plan for the period after their dismissal. Cox said she would regard it as mandatory to have clinicians on the staff to deal with clients with co-occurring disorders. Once such clients are stabilized and on medication, they are referred to mental health services.

Opening a period of questions and comments, a questioner noted the difficulty in calculating the beginning and ending of the 12 months of treatment and six months of aftercare

provided for under Proposition 36 in cases where a client relapses or has a probation violation that interrupts treatment. Is the lapse added on to the end of the regular period? Dr. Sushma Taylor said she believed it could be left to individual discretion. Toni Moore commented that a relapse or violation doesn't mean that the 12-month clock is started over again. Steve Loveseth said he felt it was important that decision-making in such cases be clinically driven. Susan Bower said that in San Diego County if a client is out of treatment for two or three months and returns after a relapse or probation violation, then the 12-month treatment period is extended for that amount of time so the person still receives 12 months of treatment. NOTE: ACLA Letter No. 02-18 addresses these issues. Interested parties may wish to refer to <http://www.adp.cahwnet.gov/SACPA/ACLA_Letter_02-18.shtml>

Another questioner noted the reference to treatment and recovery as a matter of "36 to Life" and asked for examples of how extensions of treatment into aftercare and beyond are carried out. Members of the team from Sacramento County pointed out that graduates of their program started the "36 to Life" alumni group. The group meets once a month and is beginning to provide support services for clients still in treatment. A fund-raising effort also is planned. Dr. Taylor said her program at Center Point started an alumni association about 20 years ago, and a senior staff member acts as a resource person for the association. The alumni association has a bank account, officers, and a charter of by-laws and rules. It also provides peer support, helps graduates find jobs, and buys Christmas presents for the children of people in treatment. "You need to provide some seed support at the beginning, but then you can be a sponsor or a guide and allow them to self-govern."

A questioner wondered how many had incorporated 12-step meetings such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) into their treatment regimens. Many hands were raised. Loveseth commented that he had relied on 12-step programs but thinks it is important that other options be offered. "To say you have got to do this or do that is a mistake. I do not think it is appropriate to exclude 12-step programs from the menu, but it is also not appropriate to force people to participate in them." Janice Stafford said 12-step support is included in treatment plans for most clients in Plumas County, but it is looked at on an individual basis. Loveseth also described a form of relapse prevention involving giving clients cards that have examples of negative thoughts on one side of the card and the antidote for it on the other side. It is important to give people in recovery some specific tools to use when they are faced with stress or circumstances that can lead to relapse. Moore added that it can be helpful to bring family members into a continuing care plan. "We talk about addiction as a family disease but most of our approaches tend to be just with the individual," she said. She described an ancillary program in Sacramento that provides prevention activities for the children of families in which a parent is in Proposition 36 treatment. Stafford reported that Plumas County also provides services to the children of parents in treatment.

The subject turned to vocational services, and a team member from Ventura County said a case worker from a federal work program comes in once or twice a week to meet with Proposition 36 clients who are looking for work. A public health nurse from Sacramento said her county contracts with a vocational service called Crossroads that deals primarily with persons with disabilities. She added that as a nurse familiar with health care, she has come to look at treatment as corresponding to providing "acute care" for an illness, while aftercare or continuing care is comparable to managing a "chronic disease."

Tuesday, February 4

Kathryn P. Jett opened the second plenary session of the conference with a review of the themes emerging since the first conference was held in 2001. She said it had become evident that treatment under Proposition 36 is only one point in what must be a continuum of care for those seeking recovery from addiction. At the first conference, Attorney General Bill Lockyer told the group that they were pioneering new ways to address the problem of drug addiction. At the 2002 conference, Dr. Robert Ross of The California Endowment left the group with the challenge that in their endeavors "failure is not an option." At this conference, a choir consisting of people in recovery at the Mary Lind Foundation made it evident that all concerned are "soldiers" fighting for a better life for victims of drugs.

Beth Ruyak then introduced **Mike Brady**, then Consultant in the Office of the President Pro Tempore Senator John Burton and newly appointed Deputy Secretary of the California Youth and Adult Correctional Agency, who told his own story of involvement with alcohol and drugs that led to loss of his career as an attorney, a sentence to prison, and finally the beginning of recovery more than three years ago. The eventual dismissal of his case after completing treatment was similar to the opportunities now being afforded to drug defendants through drug courts and Proposition 36. He said he was giving a public account of his experience because his recovery required rigorous honesty. "The minute I start trying to pretend that I am normal, that I am something that I am not, and I forget about the past the tragedy that I went through--my sobriety is in jeopardy," he declared. "It requires that I be completely honest with you and with myself." He related how his service on the staff of Senator John Burton led to a top administrative position for the same prison system where he was once an inmate. He also noted that a new program to help attorneys who are in trouble with drugs has been established under SB479 and currently has 115 lawyers enrolled.

Brady also warned members of the county teams that the possibility of a "realignment" solution to the state budget crisis should not be dismissed. "It may very well happen, and you need to start talking about it in your groups now, and prepare for the possibility that it will happen in the course of the budget process."

What We Have Learned from Drug Court Research That Has Application to SACPA

Steven Belenko, Ph.D.
University of Pennsylvania, Treatment Research Institute

Steven Belenko opened his presentation with a review of research about the characteristics of inmates and offenders with a history of substance abuse.

Dr. Belenko then turned to the public safety strategies that have been followed to deal with drug use and crime. The practice of providing drug treatment in prisons, which states have been adopting to an increasing degree, has had only a small effect on criminal recidivism and no effect at all on relapse to drug use when there are no provisions for aftercare, according to Dr. Belenko. "There are some positive effects but they are generally in terms of security and safety and morale within prisons."

A similar gap exists between the number who need education and vocational training and the number receiving such services while incarcerated. He described some "intermediate sanctions" applied to offenders and said research indicates some of the sanctions—such as boot camp or house arrest—have no effect on recidivism. Others, including anklet monitoring, "scared straight" programs, and intensive supervised probation, appear to have a negative effect—people do worse.

Dr. Belenko said that simple referrals to treatment also have limited effect. Programs calling for case management within the criminal justice system, including assessment and referral to treatment, show some success in leading to longer length of stay in treatment.

Summarizing this research, Dr. Belenko presented conclusions that included: "Prison does not work; treatment in prison does not last; intermediate sanctions do not work; treatment referrals do not take; and, treatment referrals with case management work a little bit." While prison treatment programs are not providing positive outcomes, drug court programs have proven successful.

Dr. Belenko then reviewed public health strategies and how they work. First, he described acute care, rehabilitation, and aftercare or continuing care as the three stages of treatment. He said treatment outcomes improve when a professional staff provides treatment and there is a good system for storing information and monitoring progress of clients.

Turning to linkage between public health and public safety strategies, Dr. Belenko noted that the earliest drug courts emerged in the 1950's in New York City and Chicago. "There was not much treatment going on, but they tried," he said. In 1989, in Dade County, Florida, the first drug court was established along the lines of what has become the current model. That model includes a number of features. It is open to offenders with no prior or current violent offenses, and the defendant pleads guilty or stipulates to the arrest report. The model provides treatment and case management; frequent urine monitoring occurs; graduated sanctions are imposed; and, rewards are provided. Most employ a non-adversarial team approach during treatment.

Dr. Belenko then reported on his own research that was based on more than 100 reviews of drug court outcomes during the 1998-2000 period. Those findings include:

- In general, drug treatment has success rates comparable to other medical interventions for chronic conditions.
- Drug courts generally use a team approach, with a long-term process.
- Drug court operations may vary based on local conditions and populations. Drug courts are so different that it is difficult to make a general statement about the recidivism rate for drug courts.
- Data on adult drug court clients look much like the data in earlier studies on offenders: long histories of drug use and criminal activity; mental health problems; and, previous treatment failures.
- Drug courts appear to do better than other treatment interventions in terms of retention and graduation. Quite impressive is the fact that close to half who start treatment in drug court complete the treatment.
- Drug use and criminal activity are relatively low during program participation.

Dr. Belenko said his research shows that drug courts provide more client contacts, court hearings, and drug tests than traditional probation or pretrial release, and that recidivism rates vary. A study of Orange County drug courts found a recidivism rate of 17 percent during the

program versus 36 percent for drug offenders overall. Baltimore drug courts showed a recidivism rate of 48 percent versus 64 percent for a control group. Less research has been done on post-program recidivism. In two courts, the drug court clients had significantly lower post-program recidivism, but in one court the drug court clients had a higher post-program recidivism rate. Out of 28 evaluations of post-program recidivism, 20 found lower recidivism rates for drug court clients than for those in a comparison group. "We can safely conclude, at least in the short term, that drug courts do have an effect on recidivism," Belenko said.

He said four fairly comprehensive cost analyses of drug courts have been conducted and concluded that drug court costs are lower than traditional processing, mostly because of reduced use of incarceration, but their costs are higher than straight diversion programs which cover lower-risk clients and provide fewer services. One study has found that drug court costs in the long term are offset by reduced crime and drug use.

Dr. Belenko listed a number of gaps in drug court research.

- How does the assessment and screening process work?
- What are the most effective treatment delivery models?
- How can adequate data systems be maintained?
- What are the barriers to identifying service needs and making appropriate referrals?
- How do different service mixes and decision-making models effect program retention and success?
- What factors involving clients, organization, and service delivery affect program outcomes?

He asserted that there is a need for longer-term follow-up data and more research on juvenile and family drug courts.

Summing up what the research shows about drug courts, Dr. Belenko said the courts he has studied embody many principles of effective treatment. One size of treatment does not fit all, and a variety of treatment options should be available. A holistic approach is important, with linkage to various community services that offenders need. And finally, more research is needed. "There is a lot we know, but there is a lot more that we do not know," he concluded.

In a brief question period, Dr. David Deitch pointed out that his studies had shown that some drug courts have a very small number of positive outcomes while others had very robust positive outcomes. Did Dr. Belenko find any characteristics associated with the best outcomes and any associated with more modest positive outcomes? Dr. Belenko said there was no consistency among those with the best outcomes, so the question would be impossible to answer. On the one hand, drug courts he studied in Denver had little impact on recidivism; but, there was practically no screening of offenders going into the drug courts. Portland, on the other hand, takes high-risk offenders and still produces impressive outcomes. Some additional research on this question has been conducted but the results have not yet been published.

Wednesday February 5

Like-Sized County Breakout Sessions

As the conference entered its final day, **David Deitch, Ph.D.** reviewed highlights of the meetings of teams from like-sized counties on Monday and Tuesday. Among the needs and concerns counties identified:

County Training Needs:

- Counties recommended that future SACPA training should be both discipline-specific and interdisciplinary, providing more opportunities for counties and other stakeholders to share best practices.
- It would be beneficial to have training at the regional level, as well as statewide. Regional training would allow more stakeholders to attend and reduce travel time and expense.
- Training for certification of service providers should be offered at the county level.
- Local training of treatment providers is needed to establish consistency around the state in reporting successful termination of treatment. It is important to have consistent data for evaluation purposes.
- It may also be helpful to have the courts create standardized forms for sign-off from treatment.

Treatment/Aftercare:

- One approach to aftercare is the development of "alumni" groups or support groups for SACPA clients who have completed treatment. These groups help support client recovery. Incentives may be created to motivate alumni to participate in the groups, or participation could be made a criterion in the court's determination of the client's completion of treatment. Volunteers, sponsors, interns, and others, can be resources for alumni groups. An alumni group could be countywide or developed by each treatment provider.
- Other aftercare strategies include a "star" calendar to recognize clients when they are doing well; community celebrations when babies are born drug-free; and, celebrating program completion with graduation ceremonies. These approaches provide short-term mileposts to reinforce and motivate people to continue doing well.

Client Flow/Courts:

- Counties observed that there is a need for more efficient processing of clients from criminal justice through treatment to aftercare.
- In some counties, the length of time from plea to treatment is too long, leading to a high rate of clients not admitted to treatment programs.
- There is a need for a matrix for decision-making regarding clients who are not amenable to treatment. The matrix could provide for involvement by all principals on the team.

- Before declaring that a client is unamenable to treatment, a case-by-case review would be made with consideration given to the client, resources, circumstances, etc.
- Counties reported ways in which the courts could be helpful in addressing client flow issues. For instance, at the time of plea, courts could sentence offenders and order them to treatment.
- At the time of plea, courts could also order clients to attend 12-step or support groups, such as Alcoholics Anonymous or Narcotics Anonymous.
- The treatment team could also be provided access to offenders in court so assessments could occur simultaneously.
- Clients could also be required to present written aftercare and post-release plans.

Cross-Jurisdictional:

County probation staff urgently need information regarding how to handle cross-jurisdictional issues

Fiscal/Revenue:

- Counties are maximizing SACPA dollars by accessing parole and Substance Abuse Services Coordinating Agency (SASCA) money first.
- One cost-saving approach at the county level is to leave clients on court probation rather than have Probation Officers supervise misdemeanor arrests. Treatment providers would report client participation or unamenability to treatment, but they should have the prerogative not to report occasional lapses.
- There can be cost savings by not filing on each parole violation, particularly on misdemeanors. The police can be informed that the violation is not being filed and why, and the report can be sent directly to parole.
- State audit policies should recognize a county's size. Additionally, if there is a SACPA "realignment," audit responsibility should be assumed by the county.

"What you see here is an extremely creative and productive collaborative outcome from these like-sized county meetings," Dr. Deitch said. "The progress, enthusiasm, dedication, commitment, and willingness to be creative and innovative and search out new possibilities is a hundred light years ahead of where we were when we began, and fifty light years ahead of where we were last year." He praised the collaboration, collegiality, and creativity seen at the conference.

Co-Occurring Disorders

Marc Schuckit, M.D., Director
Alcohol and Drug Treatment Program
San Diego Department of Veterans Affairs Hospital

Dr. Marc Schuckit, said his presentation would incorporate some of the material he had covered in an appearance at the conference a year ago, but also would address questions about

co-occurring disorders (also referred to as "dual diagnosis") that had been raised in the meantime. He pointed out that most people wake up to have "bad days" and accept it. "I don't feel all that well, but I'm OK." They distinguish between symptoms and syndromes, and know when to conclude that it is more than just a bad day. This is important to remember when dealing with people who are involved with alcohol or drugs. "If we ended up treating every alcoholic or drug dependent person who was upset because of the trouble they're in, or was recovering from the effects of intoxication or withdrawal, we would absolutely jam the system, just as if we treated every psychiatric symptom that we or those around us had as if it were a disorder we would become paralyzed and totally unable to function on a day to day basis."

Dr. Schuckit explained how a diagnosis could determine whether a problem is probably going to pass without treatment or whether it is potentially serious and requires an intervention. It would be relatively easy to decide what to do if a symptom is seen in an "unreal world" where each individual psychiatric syndrome is seen independently. The problem is deciding what to do when a person meets the criteria for more than one disorder. Virtually everyone entering the criminal justice system or a treatment facility has multiple problems. This has given rise to a vast literature on "dual diagnosis." Studies have shown that two out of three people with major alcohol or drug problems will meet the criteria for another major diagnosis. But among those two out of three, about half have another drug problem or an anti-social personality disorder that is associated with substance abuse. The focus in this discussion is on the one out of three who come in with an alcohol or other drug problem and also appear to meet the criteria for a major psychiatric disorder. Does this person need to see a psychiatrist and need to be on psychiatric medication? Experience has shown that perhaps 60 percent of offenders entering Proposition 36 programs are having psychiatric symptoms, but only 25 percent turn out to have psychiatric disorders separate from those associated with their drug use.

Dr. Schuckit went on to explain how drugs temporarily alter the chemical makeup of the brain, and psychiatric symptoms may remain for as long as a month after the use of the substance is discontinued. Such symptoms point to a substance-abuse disorder, as distinguished from a disorder that exists independently. Drug-induced states may include depression, anxiety or psychosis--all of which can look like major psychiatric disorders. He emphasized that certain symptoms are associated with the use of certain drugs. Those most likely to produce effects mimicking major psychiatric disorders are depressants (alcohol, hypnotics or sleeping pills, and anti-anxiety drugs such as Valium) and stimulants (amphetamines, cocaine, methylphenidate [Ritalin], and weight reducers).

It is not necessary to wait 30 days to see if a psychiatric symptom goes away after withdrawal from drug use, Dr. Schuckit explained. "What you do when you first see a client or patient is gather a history to try to produce the best betting odds as to which type of syndrome this is," he said. "You then begin your treatment plan based on what the odds are based on that history." This does not require a psychiatrist, he pointed out. Counselors and nurses can be taught to use this approach. It should be established whether the symptoms are consistent with use of the kind of drug the person has been using. Those who have been using stimulants may have symptoms of mania, but those using alcohol or other depressants would not have such symptoms. Finally, a "timeline" can be developed to indicate whether the person has ever had psychiatric symptoms at times when he or she was not heavily into use of drugs. For example, those who began having psychiatric symptoms before getting involved with drugs—or have such symptoms during intervals when they were not using drugs--probably have an independent

mental disorder. He gave an example of how creating a timeline of a person's history can help establish this.

Dr. Schuckit then turned to a series of questions. First, how can people work together to evaluate patients and determine whether their symptoms are related only to drug use or indicate a major depressive disorder? "My philosophy is that we are there to serve the patient's needs," he replied, adding that the same would apply to clients in the criminal justice system. Those who have resources that can be used to conduct the evaluation need to work together in a way that avoids turf wars. One way is to integrate existing programs, as the VA Hospital in San Diego has done. He described how the hospital's psychiatric unit and drug and alcohol treatment unit help each other in determining the proper treatment for patients whose diagnosis is not yet clear. He said this could be carried out at the community level, since a correct diagnosis is in the best interest of both groups of treatment providers. An alternative is to establish a new co-occurring disorder diagnosis program with the appropriate staff and services. (He suggested that Proposition 36 teams in Southern California take greater advantage of treatment services provided by the Department of Veterans of Affairs). He then described how his treatment unit uses cognitive and behavioral therapy during the first few days of a patient's treatment to help determine whether symptoms are connected with drug use or reflect an independent psychiatric disorder. "The evaluation begins immediately, and helps me to decide which people I'm likely to start on anti-depressant medication and those with whom I'm more likely to wait a bit longer." As days go by, it is necessary to re-evaluate and observe regularly.

Dr. Schuckit gave an example of how a Proposition 36 team might proceed when an offender appears to have a psychosis, such as schizophrenia, as well as a history of drug use. He described characteristics of schizophrenia that might be evident in observing the person, such as hallucinations and paranoia. Heavy doses of certain stimulants, including amphetamines and cocaine, will cause anyone to show signs of schizophrenia, but those signs will disappear within days or weeks. A history and timeline will help clarify whether the individual had a psychosis prior to becoming a user of stimulants. If the psychosis appears to be an independent problem, the patient can then be treated with appropriate drugs.

He then discussed other questions that came out of the Proposition 36 conference in September 2002:

- What is the appropriate housing for a client who is diagnosed with a psychiatric disorder as well as a substance abuse disorder? "If it's really a substance-induced disorder, the psychiatric symptoms are irrelevant. The symptoms will go away. You do whatever placement is appropriate for alcohol or drug treatment." On the other hand, if the client has a major psychiatric disorder and alcohol or drugs are a sideissue making it worse, then the placement will be for a longer term in a residential facility for people with psychiatric disorders.

- Do the usual modes of treatment for people with alcohol or drug dependence work for people with psychiatric disorders? Dr. Schuckit described how the treatment for substance dependence is aimed at changes in lifestyle (as is treatment for chronic diseases like diabetes) and education as ways to avoid relapse. Experience indicates that once people with major depressive disorder or manic depressive disease get into treatment for their psychiatric disorder and begin functioning well, they can do as well as most other patients in substance abuse treatment. Schizophrenia patients are a

little harder to treat for substance abuse, he added, but with extra care they can be accommodated. People with psychiatric disorders also can do well in 12-step programs, and special groups for patients with co-occurring disorders are being developed in Southern California.

- Questions also were raised earlier about training of staff. "In our inpatient alcohol and drug treatment program we try to cross-train our staff to recognize major psychiatric disorders and refer the patient to the inpatient or outpatient psychiatric unit, and people on the psychiatric side are trained to recognize alcohol and drug problems. We do this by taking advantage of people in both programs who are good at what they do, and have them do a bit of cross-training." Staff may need re-training from time to time as a form of "relapse prevention" in their commitment to doing the kind of evaluation these cases require.

A member of the audience raised the issue of anxiety disorders. Dr. Schuckit responded that there is no evidence that alcohol or drug dependence increases risk for major depressive disorder or obsessive-compulsive disorder, but there is a small but significant increase of risk for two major anxiety problems, panic disorder and social phobia, and possibly also for post-traumatic stress disorder. For example, if the risk of alcohol dependence in all men is about 15 percent, the risk for a man with panic disorder may go up to 20 percent. Schizophrenia and manic depressive or bi-polar disease entail a more significant risk of a "crossover" with alcohol and drug dependency, where the risk rises to about 40 percent.

Another questioner asked about the prevalence of various psychiatric problems in the criminal justice population. Among chronic repetitive felons, especially violent felons, studies indicate that 75 to 80 percent have the anti-social personality disorder, Dr. Schuckit replied. This is a lifelong condition, with severe impulsivity. Almost all of these people are alcohol or drug dependent. Over the last couple of decades, a rising proportion of people with schizophrenia are entering the criminal justice system because they are not being cared for in the mental health system. Dr. Schukit estimated that there is a tenfold higher rate of schizophrenics in the criminal justice system than in the general population; that is, about 10 percent in criminal justice compared to one percent in the general population. He would also guess that there is an elevated risk for people with manic depressive disease, but he does not think people with anxiety disorders or major depressive disorders would be over-represented. Another group over-represented would be people with brain damage.

Success Stories from the Home Front

In the final event of the conference, David Deitch recalled that a group of Proposition 36 clients appeared in a film called "Success Unfolding" at the conference in 2002, and announced that some of the same clients were present at this time to tell how they have fared during their treatment and recovery. **Beverly Fischer** of the San Diego program Stepping Stones introduced a panel of five offenders whose recovery is progressing under Proposition 36. She asked each to describe where they are today in the Proposition 36 process. **Steve**, who entered the program in October 2000, said he is now in aftercare and is "living life on life's terms." He is attending 12-step meetings and said he has learned to rely on help from others to stay clean and sober. He

believes the only way he can keep what he has today is by "giving it away"--by helping others. He has a job and he is paying child support.

Michael, who became a Proposition 36 client in April 2000, said he did not know what the program was at that time but he would have taken any opportunity to stay out of jail. In the education phase, or Level 1, he continued to use drugs, and when he was referred to a residential program he at first regarded that as being "locked up." However, he discovered he could not do it "my way." He said he had learned that he was not responsible for being an addict but he was responsible for his recovery. He now has been clean for 10 months. He has a job providing security and landscaping service in an apartment complex, and helps with arts and crafts projects for children who live there.

Michelle, who became a Proposition 36 client in October 2001, told how she made a "bad choice" after 11 months in the program and relapsed. One lesson she learned was not to have a relationship during the first year. "I found I was not emotionally capable of taking care of anybody else because I can't take care of myself." She received help from other recovering addicts in getting back into the program, saying she is no longer working "*my* program" but is working "*the* program" and not trying to give herself special considerations. She said she grew up in a dysfunctional family but realizes this was not her fault. "I've learned a lot about myself, about being honest, about self-acceptance, and about humility."

Rex has been a resident of Stepping Stones since entering the Proposition 36 program in August 2001 after a lengthy involvement with the criminal justice system that included 13 years in prison. He told the Judge that Proposition 36 offered the first chance he had ever had to go to treatment for his drug addiction. His treatment was interrupted in January 2002 when he had a triple by-pass operation to correct a heart condition. His doctor has told him he was amazed to see him remain clean throughout this period. "Today my needs and wants are different from what they were when I was addicted," he said. "When I was an addict it was all about Rex. Now it is about other people." His neighbors once regarded him as "not a nice guy" but now they wave to him and ask him how he is doing. He said he is "giving back" by helping an elderly couple with their household chores.

Eddie became one of the first Proposition 36 clients in July 2001 and was the first to graduate from the Proposition 36 program at Stepping Stones. The Judge recently dismissed his case. In the last days of his drug use, he said, he had become a person he did not want to be. In treatment he discovered that there was still a good person in him. "The program has made me realize the truth about drug addiction…I am not part of Stepping Stones now but I see people at 12-step meetings and keep in touch with my counselor. I go to hospitals and talk to people in detox. I am a secretary of a 12-step meeting. As long as I am helping somebody else it is helping me." He works as a union ironworker, his trade for many years. Some of his co-workers are in recovery, too, and they bond together. He said he wanted to thank the voters who approved Proposition 36 because "without it I would not be here today."

After hearing the success stories of the five Proposition 36 treatment participants, attendees left the conference with the knowledge that their efforts—in a variety of programs related to SACPA—have helped make Proposition 36 work. Attendees gained confidence that those involved in the Proposition 36 effort can continue building on their successes as they seek new and innovative ways to provide needed services to SACPA clients.

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